CHAPTER V. AMBULATORY SURGERY

This section of the report presents information about ambulatory surgery collected from hospital-based ambulatory surgery programs and freestanding ambulatory surgery centers (FASCs).

Facilities that Reported Data

BHI collected ambulatory surgery data from 124 GMS hospitals and 31 FASCs during 2001. They submitted records on 683,130 patients (584,513 at hospitals and 98,617 at FASCs).

FASC Closings

Eau Claire Surgery Center, Eau Claire, August 15, 2001

Healthsouth Oak Leaf Surgery Center, Eau Claire, November 26, 2001

BayCare Surgery Center-East, Green Bay, September 25, 2001

BayCare Surgery Center-West, Green Bay, September 25, 2001

GMS Hospitals

For openings, closings, and special circumstances for GMS hospitals, see the table on page 37.

Selected Data Reported by Wisconsin Hospitals and FASCs

BHI collects data on all ambulatory surgery procedures performed in hospital-based outpatient surgery units and Medicare-certified FASCs. However, a significant number of ambulatory surgeries performed in Wisconsin are not included in BHI's database. This is because ambulatory surgeries are also performed in settings which are not required to submit data to BHI, such as FASCs that are not Medicare-certified, and clinics and urgent care centers that are not owned and operated by hospitals.

Charges in these reports represent the average amount billed for a surgical episode and are not necessarily the facility's routine charge for a particular type of surgery. Each record BHI collects contains a code for the principal procedure (the reason for the surgery) and codes for up to five other procedures. A patient who had multiple procedures should expect to have higher charges than one who had only one procedure.

The 20 procedures for which individual facility data are presented in this report are those principal procedures that were most frequently reported in 2000.

CPT-4 Codes vs. ICD-9-CM Codes

Hospitals and FASCs typically use different coding systems to report data to BHI. FASCs generally use CPT-4 procedure codes. Hospitals tend to use ICD-9-CM codes, although they may also use CPT-4 codes for Medicare patients, such as those undergoing cataract surgery.

The two coding systems are similar but not identical. For example, under CPT-4 coding, cataract removal and lens insertion can be reported as a single code; under ICD-9-CM coding, each step of the surgery must be reported as a separate code.

In order to present information on hospitals and FASCs together, it is necessary to convert the data into one common set of procedure codes. To do this, BHI uses computer software expressly designed to convert CPT-4 codes to ICD-9-CM codes.

How to Read The Ambulatory Surgery Tables

Summary Tables

The first part of the ambulatory surgery section presents data in the following summary tables:

- Table 25 presents the number of cases, the average charge and the quartile charges for 20 selected procedures (selected because they were the most frequently reported during 2000 by hospitals and FASCs in Wisconsin).
- Table 26 presents the age and sex distributions for patients undergoing these 20 procedures.
- Table 27 shows the expected primary pay sources for patients undergoing these 20 procedures.
- Tables 28-30 present the ICD-9-CM codes, number of cases, average charge, and total charges generated by the 40 most frequently reported ambulatory procedures, the 20 most expensive procedures (for which at least 5 cases were reported), and the 20 procedures generating the greatest amounts in overall charges during all of 2001.
- Table 31 sorts all the ambulatory procedures reported to BHI during 2001 into categories that describe the part of the body or system on which they were performed. The category Diagnostic/Therapeutic contains miscellaneous procedures not assigned to any of the other categories.

Comparison Group Tables

For each of the 20 selected surgical procedures, there is a table showing the number of cases, average charge per case, standard deviation, and the 25th, 50th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th percentile distribution of charges statewide for all facilities, statewide for hospitals only, and statewide for FASCs only. The same data elements are presented for each three-digit ZIP code area in the state with hospital and FASC data combined. (See graphic on page 333.)

Facility-Specific Tables

For each procedure a table shows, by facility, the number of cases, average charge per case, standard deviation, and median charge. Data are sorted by three-digit ZIP code area and by city within each area. Hospitals and FASCs appear on the same tables, with an "H" designating a Hospital and an "F" a FASC. (See graphic on page 334.)

Facilities that reported fewer than three cases of a given procedure do not appear in the table for that procedure. However, their data are included in the statewide and ZIP code area totals. Facilities that reported three or four cases for a given procedure do appear in the table for that procedure; however, charge data are not provided, due to the small number of cases.

Comparison Group Tables

# of Cases is the number of cases for which this procedure was listed as the principal procedure.

Average Charge is calculated by totaling the charges for all patients assigned to the surgical category and dividing by the number of cases. It represents the amount, on average, a patient undergoing this type of ambulatory surgery was charged.

Standard Deviation is a measure of the average variation above or below the mean, or average, charge. When charges are in a normal distribution, approximately 68 percent of the cases will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

Percentile Charges mark the point above and below which some percentage of the patients' charges fall. For instance, half the patients were charged less than the 50th percentile, or median charge, and half were charged more. Similarly, 95 percent were charged less than the 95th percentile, and 5 percent were charged more.

ICD-9-CM Code 45.23: Colonoscopy

January – December 2001

Note: Utilization and charge data are per surgical episode. They may include procedures other than the principal procedure.

	# OF CASES	AVERAGE CHARGE	STANDARD DEVIATION	PERCENTILE CHARGES								
				25TH	*50TH*	*60TH*	*70TH*	*75TH*	*80TH*	*85TH*	*90TH*	*95TH*
STATEWIDE DATA												
All Facilities	49,368	$1,244	$551	$888	$1,133	$1,245	$1,380	$1,491	$1,641	$1,771	$1,942	$2,284
FASCs	6,360	1,209	487	964	1,118	1,155	1,359	1,373	1,448	1,756	1,956	1,956
Hospitals	43,008	1,249	560	887	1,136	1,258	1,416	1,515	1,656	1,771	1,909	2,337
3 DIGIT ZIP CODE AREA DATA												
530**	3,980	$1,414	$447	$1,056	$1,310	$1,486	$1,616	$1,666	$1,695	$1,823	$2,047	$2,208
531**	4,709	1,409	406	1,224	1,353	1,451	1,532	1,595	1,646	1,718	1,885	1,956
532**								1,899	2,046	2,337	2,458	2,616
534**								1,360	1,432	1,690	2,230	2,435
535**								1,488	1,610	1,886	2,122	2,277
537**								915	922	935	977	1,076
538**								2,388	2,425	2,523	2,549	2,674
539**								1,324	1,369	1,491	1,601	1,992
540**	760	1,233	280	1,012	1,255	1,268	1,296	1,313	1,329	1,400	1,580	1,673
541**	1,055	$1,010	$251	$856	$898	$1,005	$1,045	$1,120	$1,183	$1,262	$1,293	$1,359

The number of cases and the distribution of charges are summarized for the entire state and for each three-digit ZIP code area in the state. These figures include both hospitals and FASCs. Statewide data are also presented for hospitals only, and for FASCs only.

Facility-Specific Tables

ICD-9-CM Code (International Classification of Diseases, 9th Revision, Clinical Modification) is a coding system used by facilities, on patient records and billing forms, to designate which surgical procedure(s) were performed.

# of Cases is the number of cases at the facility for which this ICD-9-CM code was listed as the principal procedure. Facilities reporting fewer than three cases do not appear in the tables, although their data are included in the statewide and three-digit ZIP code area data. Facilities that reported three or four discharges do appear in the tables, but no charge data are presented for those cases.

Average (Mean) Charge is calculated by totaling the charges for all cases with this principal procedure and dividing by the number of cases. It represents the amount, on average, a patient assigned to this surgical category was charged.

Median Charge is the amount that half the patients were charged more than and half were charged less than.

Standard Deviation is a measure of the average variation above or below the average, or mean, charge. When charges are in a normal distribution, approximately 68 percent of the cases will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

ICD-9-CM Code 45.23: Colonoscopy

January - December 2001

Note: Utilization and charge data are per surgical episode. They may include procedures other than the principal procedure.

BY FACILITY WITHIN 3 DIGIT ZIP CODE AREAS
(Excludes facilities with fewer than 3 cases)

Facilities are sorted by three-digit ZIP code area. Within each area, Facilities are sorted alphabetically by city. An "H" indicates the facility is a hospital; an "F" designates a FASC.

		TYPE OF FACILITY	# OF CASES	AVERAGE CHARGE	MEDIAN CHARGE	STANDARD DEVIATION
530						
Elmbrook Memorial Hospital	Brookfield	H	705	$1,290	$1,271	$329
Calumet Medical Center, Inc.	Chilton	H	124	2,239	2,193	210
Aurora Medical Center	Hartford	H	137	2,162	2,079	302
Community Memorial Hospital	Menomonee Falls	H	155	1,449	1,373	286
Menomonee Falls Amb. Surgery Center	Menomonee Falls	F	608	1,033	964	262
St. Mary's Hospital-Ozaukee	Mequon	H	526	1,743	1,669	353
Oconomowoc Memorial Hospital	Oconomowoc	H	354	1,581	1,558	249
Sheboyga		H	559	1,141	1,094	214
St. Nichol		H	246	1,243	1,245	222
Watertow		H	187	1,625	1,576	382
St. Josep		H	150	2,073	2,089	312
West Ben		F	229	1,118	1,050	197
531						
Memorial Hospital Corp. of Burlington	Burlington	H	337	1,628	1,602	261
Lakeland Medical Center, Inc.	Elkhorn	H	464	1,783	1,714	399
Aurora Medical Center - Kenosha	Kenosha	H	187	1,818	1,675	482
Kenosha Hospital and Medical Center	Kenosha	H	880	1,018	894	311
Mercy Walworth Ambulatory Surgery Ctr.	Lake Geneva	F	99	1,326	1,360	181
Aurora Ambulatory Surgery Ctr.-Waukesha	Waukesha	F	336	1,941	1,956	514
Waukesha Memorial Hospital, Inc.	Waukesha	H	2,406	1,347	1,269	213
532						
Wisconsin Health Center, LLC	Greenfield	F	55	1,300	1,300	0
Aurora Sinai Medical Center	Milwaukee	H	454	1,992	1,897	673

Table 25. Summary of selected ambulatory surgical procedure data, Wisconsin GMS hospitals and FASCs, 2001

ICD-9-CM Code	Procedure	Number of Cases	Avg. Charge	Percentile Distribution of Charges 25th	50th	75th
03.91	Injection of Spinal Canal for Analgesia	16,289	734	450	650	917
03.92	Injection of other Agent into Spinal Canal	26,938	734	531	651	928
04.43	Carpal Tunnel Release	11,572	2,175	1,405	1,978	2,674
13.41	Phacoemulsification and Aspiration of Cataract	28,304	3,598	2,657	3,480	4,388
13.59	Other Extracapsular Extraction of Lens	13,843	2,735	2,140	2,711	3,095
20.01	Myringotomy with Insertion of Tube	10,933	1,805	1,208	1,522	2,185
28.3	Tonsillectomy with Adenoidectomy	6,788	2,846	2,150	2,660	3,411
37.22	Left Heart Cardiac Catheterization	12,446	6,341	4,742	5,952	7,275
42.92	Dilation of Esophagus	6,894	1,390	926	1,223	1,614
45.13	Other Endoscopy of Small Intestine	13,311	1,150	762	949	1,323
45.16	EGD† with Closed Biopsy	35,691	1,516	995	1,301	1,806
45.23	Colonoscopy	49,368	1,244	888	1,133	1,491
45.24	Flexible Sigmoidoscopy	12,080	577	261	420	744
45.25	Endoscopic Biopsy of Large Intestine	18,101	1,569	1,048	1,412	1,956
45.42	Endoscopic Polypectomy of Large Intestine	35,856	1,709	1,155	1,554	2,100
51.23	Laparoscopic Cholecystectomy	9,191	6,660	4,821	6,488	7,932
57.32	Other Cystoscopy	9,915	1,575	767	1,166	1,930
80.6	Excision of Semilunar Cartilage of Knee	14,162	4,325	2,936	3,906	5,100
85.21	Local Excision of Lesion of Breast	9,287	3,155	1,935	2,660	3,755
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,763	1,084	204	503	1,576

Note: Charges may reflect charges for other ambulatory procedures performed during the same surgical episode. Refer to page 333 for an explanation of percentiles.

† Esophagogastroduodenoscopy

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 26. Age and sex distribution of persons undergoing selected ambulatory procedures, Wisconsin GMS hospitals and FASCs, 2001

ICD-9-CM Code	Procedure	Age Groupings 0-14	15-44	45-64	65+	Sex Male	Female
03.91	Injection of Spinal Canal for Analgesia	0.0%	27.3%	36.7%	36.0%	43.4%	56.6%
03.92	Injection of other Agent into Spinal Canal	0.2	29.1	34.3	36.4	44.9	55.1
04.43	Carpal Tunnel Release	0.0	33.4	41.3	25.3	39.5	60.5
13.41	Phacoemulsification and Aspiration of Cataract	0.1	1.5	14.5	83.9	36.8	63.2
13.59	Other Extracapsular Extraction of Lens	0.2	1.7	15.4	82.8	37.8	62.2
20.01	Myringotomy with Insertion of Tube	92.1	3.3	1.8	2.8	58.5	41.5
28.3	Tonsillectomy with Adenoidectomy	91.2	8.8	0.0	0.0	46.5	53.5
37.22	Left Heart Cardiac Catheterization	0.0	8.1	48.2	43.7	59.9	40.1
42.92	Dilation of Esophagus	0.8	19.3	34.0	46.0	50.3	49.7
45.13	Other Endoscopy of Small Intestine	0.8	32.4	34.9	31.9	39.6	60.4
45.16	EGD† with Closed Biopsy	2.8	28.1	37.2	31.9	45.0	55.0
45.23	Colonoscopy	0.1	14.4	49.3	36.3	40.5	59.5
45.24	Flexible Sigmoidoscopy	0.1	14.4	53.7	31.8	47.5	52.5
45.25	Endoscopic Biopsy of Large Intestine	1.8	30.0	38.6	29.6	40.5	59.5
45.42	Endoscopic Polypectomy of Large Intestine	0.1	7.3	47.4	45.3	54.0	46.0
51.23	Laparoscopic Cholecystectomy	0.2	48.8	36.3	14.7	22.3	77.7
57.32	Other Cystoscopy	1.5	16.9	29.0	52.6	59.1	40.9
80.6	Excision of Semilunar Cartilage of Knee	0.6	35.2	49.2	15.0	58.8	41.2
85.21	Local Excision of Lesion of Breast	0.2	33.4	42.7	23.7	3.0	97.0
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	6.8	33.6	31.0	28.6	46.8	53.2

Note: Rows may not total 100% due to rounding.

† Esophagogastroduodenoscopy

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 27. Expected primary pay source distribution of persons undergoing selected ambulatory procedures, Wisconsin GMS hospitals and FASCs, 2001

ICD-9-CM Code	Procedure	T18	T19	Other Gov't	Commercial Insurance	Self-Pay	Unknown
03.91	Injection of Spinal Canal for Analgesia	36.2%	3.5%	0.4%	58.8%	1.0%	0.0%
03.92	Injection of other Agent into Spinal Canal	36.9	2.8	0.5	58.8	0.9	0.1
04.43	Carpal Tunnel Release	24.7	3.3	0.4	70.6	0.9	0.1
13.41	Phacoemulsification and Aspiration of Cataract	80.8	1.0	0.2	17.5	0.5	0.0
13.59	Other Extracapsular Extraction of Lens	77.8	1.4	0.2	19.2	0.6	0.8
20.01	Myringotomy with Insertion of Tube	1.7	16.8	0.4	80.6	0.4	0.1
28.3	Tonsillectomy with Adenoidectomy	0.0	13.4	0.6	85.1	0.7	0.2
37.22	Left Heart Cardiac Catheterization	43.4	2.4	0.7	52.8	0.7	0.1
42.92	Dilation of Esophagus	47.1	2.1	0.8	48.9	1.0	0.1
45.13	Other Endoscopy of Small Intestine	33.3	4.4	0.8	60.0	1.2	0.2
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	32.6	4.3	0.7	61.4	0.9	0.2
45.23	Colonoscopy	35.7	1.7	0.5	61.4	0.6	0.2
45.24	Flexible Sigmoidoscopy	31.4	1.7	0.7	65.0	0.9	0.3
45.25	Endoscopic Biopsy of Large Intestine	29.5	2.9	0.6	66.1	0.8	0.1
45.42	Endoscopic Polypectomy of Large Intestine	43.2	1.3	0.4	54.5	0.5	0.1
51.23	Laparoscopic Cholecystectomy	15.3	6.7	0.8	75.0	2.0	0.2
57.32	Other Cystoscopy	51.0	3.3	0.7	44.1	0.7	0.1
80.6	Excision of Semilunar Cartilage of Knee	14.9	2.1	0.4	81.5	0.9	0.3
85.21	Local Excision of Lesion of Breast	24.1	3.8	1.0	69.7	1.4	0.1
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	28.1	3.1	0.8	66.1	0.9	0.9

Note: Rows may not total 100% due to rounding.

T18 refers to Medicare. T19 refers to Medical Assistance.

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 28. Most frequently performed ambulatory surgical procedures, Wisconsin GMS hospitals and FASCs, 2001

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
45.23	Colonoscopy	49,368	$1,244	$61,415,176
45.42	Endoscopic Polypectomy of Large Intestine	35,856	1,709	61,262,584
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	35,691	1,516	54,116,114
13.41	Phacoemulsification and Aspiration of Cataract	28,304	3,598	101,838,069
03.92	Injection of other Agent into Spinal Canal	26,938	734	19,760,487
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,763	1,084	22,512,077
45.25	Endoscopic Biopsy of Large Intestine	18,101	1,569	28,408,830
03.91	Injection of Spinal Canal for Analgesia	16,289	734	11,948,515
80.6	Excision of Semilunar Cartilage of Knee	14,162	4,325	61,255,398
13.59	Other Extracapsular Extraction of Lens	13,843	2,735	37,859,083
45.13	Other Endoscopy of Small Intestine	13,311	1,150	15,311,782
37.22	Left Heart Cardiac Catheterization	12,446	6,341	78,915,999
45.24	Flexible Sigmoidoscopy	12,080	577	6,969,851
04.43	Carpal Tunnel Release	11,572	2,175	25,174,322
20.01	Myringotomy with Insertion of Tube	10,933	1,805	19,728,652
57.32	Other Cystoscopy	9,915	1,575	15,613,736
85.21	Local Excision of Lesion of Breast	9,287	3,155	29,304,976
51.23	Laparoscopic Cholecystectomy	9,191	6,660	61,211,756
42.92	Dilation of Esophagus	6,894	1,390	9,582,503
28.3	Tonsillectomy with Adenoidectomy	6,788	2,846	19,315,505
13.64	Discission of Secondary Membrane After Cataract	6,577	862	5,670,406
45.43	Endoscopic Destruction of Lesion/Tissue of Large Intestine	6,456	1,351	8,722,644
85.11	Closed (Percutaneous)(Needle) Breast Biopsy	5,749	1,717	9,870,353
04.81	Injection of Anesthetic into Peripheral Nerve for Analgesia	5,408	1,163	6,290,692
48.36	Endoscopic Polypectomy of Rectum	5,352	1,589	8,502,318
81.92	Injection of Therapeutic Substance into Joint or Ligament	4,781	628	3,000,223
28.2	Tonsillectomy without Adenoidectomy	3,687	3,044	11,222,769
69.09	Other Dilation and Curettage (D&C)	3,633	3,423	12,434,135
81.83	Other Repair of Shoulder	3,579	6,205	22,206,014
86.24	Chemosurgery of Skin	3,553	548	1,947,199
66.29	Bilateral Endoscopic Destr./Occlusion of Fallopian Tubes	3,524	3,772	13,291,751
83.63	Rotator Cuff Repair	3,179	7,161	22,764,675
77.51	Bunionectomy with Osteotomy of the First Metatarsal	3,170	4,205	13,329,056
53.04	Repair of Indirect Inguinal Hernia w/Graft or Prosthesis	3,121	4,567	14,254,449
53.00	Unilateral Repair of Inguinal Hernia	2,731	3,353	9,157,143
82.21	Excision of Lesion of Tendon Sheath of Hand	2,686	2,470	6,635,388
57.49	Oth. Transurethral Excision/Destr. Lesion/Tissue of Bladder	2,645	3,516	9,298,916
53.49	Other Umbilical Herniorrhaphy	2,630	3,255	8,560,052
53.03	Repair of Direct Inguinal Hernia with Graft or Prosthesis	2,600	4,552	11,834,680
37.23	Combined Right/Left Heart Cardiac Catheterization	2,490	7,392	18,406,532

Note: Charges may reflect charges for other procedures performed during the same surgical episode.

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 29. Most expensive ambulatory surgical procedures (with at least 5 cases reported), Wisconsin GMS hospitals and FASCs, 2001

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
20.98	Implant/Replace Cochlear Prosthetic Device, Multiple Channel	7	$51,829	$362,806
37.94	Implant/Repl. Auto. Cardioverter/Defibrillator, Total Sys. (AICD)	108	49,623	5,359,242
20.96	Implant/Repl. Cochlear Prosthetic Device, Not Otherwise Specified	50	44,917	2,245,856
33.51	Unilateral Lung Transplantation	5	43,167	215,837
37.98	Replace Automatic Cardioverter/Defibrillator Pulse Generator Only	188	38,591	7,255,046
37.82	Initial Insertion of a Single-Chamber Device, Rate Responsive	32	26,956	862,595
02.93	Implantation of Intracranial Neurostimulator	12	25,261	303,128
36.05	Multiple Vessel PTCA† w/wo/Mention of Thrombolytic Agent	162	24,181	3,917,397
37.83	Initial Insertion of Pacemaker with Dual-Chamber Device	158	23,005	3,634,729
36.02	1 Vessel PTCA† or Coronary Atherectomy w/Thrombolytic Agent	12	22,955	275,458
92.30	Stereotactic Radiosurgery, Not Otherwise Specified	76	22,189	1,686,346
60.99	Other Operations on Prostate	36	21,277	765,968
04.92	Implantation or Replacement of Peripheral Neurostimulator	78	20,747	1,618,233
37.34	Catheter Ablation of Lesion or Tissue of Heart	693	20,352	14,104,241
37.99	Other Operations on Heart and Pericardium	14	19,762	276,667
37.97	Replacement of Automatic Cardioverter/Defibrillator Lead(s) Only	14	19,329	270,601
36.01	Single Vessel PTCA† wo/Mention of Thrombolytic Agent	648	18,962	12,287,532
37.72	Initial Insertion of Transvenous Leads into Atrium and Ventricle	69	18,858	1,301,184
37.81	Initial Insert. 1-Chamber Device not Specified as Rate Responsive	28	17,897	501,104
37.27	Cardiac Mapping	11	17,583	193,418

Note: Charges may reflect charges for other procedures performed during the same surgical episode

†PTCA: Percutaneous Transluminal Coronary Angioplasty

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 30. Highest total charge-generating ambulatory surgical procedures, Wisconsin GMS hospitals and FASCs, 2001

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
13.41	Phacoemulsification and Aspiration of Cataract	28,304	$3,598	$101,838,069
37.22	Left Heart Cardiac Catheterization	12,446	6,341	78,915,999
45.23	Colonoscopy	49,368	1,244	61,415,176
45.42	Endoscopic Polypectomy of Large Intestine	35,856	1,709	61,262,584
80.6	Excision of Semilunar Cartilage of Knee	14,162	4,325	61,255,398
51.23	Laparoscopic Cholecystectomy	9,191	6,660	61,211,756
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	35,691	1,516	54,116,114
13.59	Other Extracapsular Extraction of Lens	13,843	2,735	37,859,083
85.21	Local Excision of Lesion of Breast	9,287	3,155	29,304,976
45.25	Endoscopic Biopsy of Large Intestine	18,101	1,569	28,408,830
04.43	Carpal Tunnel Release	11,572	2,175	25,174,322
83.63	Rotator Cuff Repair	3,179	7,161	22,764,675
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,763	1,084	22,512,077
81.45	Other Repair of the Cruciate Ligaments	2,480	9,023	22,377,469
81.83	Other Repair of Shoulder	3,579	6,205	22,206,014
03.92	Injection of other Agent into Spinal Canal	26,938	734	19,760,487
20.01	Myringotomy with Insertion of Tube	10,933	1,805	19,728,652
28.3	Tonsillectomy with Adenoidectomy	6,788	2,846	19,315,505
37.23	Combined Right/Left Heart Cardiac Catheterization	2,490	7,392	18,406,532
39.50	Angioplasty or Artherectomy of Non-Coronary Vessel	2,046	8,816	18,036,570

Note: Charges may reflect charges for other procedures performed during the same surgical episode

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 31. Ambulatory surgical procedures, by major category, Wisconsin GMS hospitals and FASCs, 2001

Category of Surgical Procedure	Number of Cases	Total Charges
Cardiovascular	30,576	$225,412,806
CPT Codes Not Converted	364	393,657
Diagnostic/Therapeutic	11,653	35,890,185
Digestive	232,130	456,731,364
Ear	14,978	37,492,210
Endocrine	1,811	5,640,162
Eye	66,562	197,072,358
Female Genital	27,281	97,116,741
Hemic/Lymphatic	3,383	10,680,903
Integumentary	61,266	128,730,057
Male Genital	9,417	24,504,288
Musculoskeletal	88,253	362,921,748
Nervous	69,418	89,989,440
Nose/Mouth/Pharynx	29,104	92,227,514
Obstetrical	4,483	2,582,593
Respiratory	8,120	21,012,012
Urinary	24,331	66,032,997
Statewide Totals	683,130	$1,854,431,033

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Caveats/Data Limitations for Ambulatory Surgery Data

1. The ambulatory surgery utilization and charge data in this report are drawn from the federal billing form HCFA-1450 (UB-92) and/or the federal billing form HCFA-1500 as submitted by 124 GMS hospitals and 31 FASCs. The charge data taken from these forms have not been audited. **As a result, the charge data provided in this report may differ from audited financial data.**
2. The reported payment sources are based on first billings rather than actual revenue sources. Therefore, the reported distribution of payment sources in this report may differ from the actual distribution of payments collected.
3. Utilization and charge figures of ambulatory surgery data were not adjusted for severity, case mix, or any of a variety of other factors that could affect comparisons among facilities. All interpretations of actual data and all comparisons of one facility to another should be made with caution. In addition to case mix and severity, regional pricing differentials and variations in the types of services offered can affect levels of utilization or charges. Also, facility record-keeping and internal information systems vary in their levels of sophistication. This may affect the quality of the data submitted by individual facilities.
4. Each facility was asked to list one principal procedure and up to five secondary procedures per record for each surgical episode.
5. The charges listed in the text and tables are for each record in the database, not for individual procedures. A case may include more than one procedure. For example, a woman having a breast biopsy may also have an excision of other breast tissue or lab and x-ray procedures. Since comparisons should be made only between patients undergoing the same combination of procedures, more detailed information is required to enable a full comparison between patients and facilities. In addition, differences in facility billing practices may affect the distribution of charges. For example, a selected follow-up procedure to cataract surgery may be reported to BHI either as part of the basic surgical episode or as a separate episode.
6. Charge data for individual facilities are not listed if fewer than five procedures were reported. However, the data are included in the statewide figures.
7. The charges that facilities report for outpatient procedures exclude professional fees.

Ambulatory Surgical Procedures Used in the Report

The report provides in-depth coverage of the following 20 procedures:

Carpal Tunnel Release - ICD-9-CM code 04.43; CPT-4 codes 29848 and 64721: the surgical relief of pressure of the median nerve at the wrist. It is commonly performed on persons whose jobs require frequent repetitive hand motions (e.g., typing).

Colonoscopy - ICD-9-CM code 45.23; CPT-4 code 45378: a diagnostic procedure performed on the large intestine, using flexible fiber optics (excludes flexible sigmoidoscopy).

Dilation of Esophagus - ICD-9-CM code 42.92; CPT-4 codes 43220, 43226, 43248, 43249, 43450, 43453, 43456, 43458, and 43510: the stretching increase in the size of the caliber of the esophagus.

Endoscopic Biopsy of Large Intestine – ICD-9-CM code 45.25; CPT-4 codes 44100, 44389, 45331, and 45380: the removal of living large intestine tissue for microscopic examination by a closed technique. Colonoscopy with biopsy. Excludes proctosigmoidoscopy with biopsy.

Endoscopic Polypectomy of Large Intestine - ICD-9-CM code 45.42; CPT-4 codes 44392, 44394, 45308, 45309, 45315, 45333, 45338, 45339, and 45385: the excision of large intestine polyp performed by an endoscopic technique.

Esophagogastroduodenoscopy (EGD) with Closed Biopsy - ICD-9-CM code 45.16; CPT-4 code 43239: biopsy of one or more sites involving the esophagus, stomach, and/or duodenum.

Excision of Semilunar Cartilage of Knee - ICD-9-CM code 80.6; CPT-4 codes 27332, 27333, 29880, and 29881: the cutting repair of a crescent-shaped portion of the knee joint cartilage. The procedure facilitates knee joint motion hampered by excess cartilage growth.

Flexible Sigmoidoscopy - ICD-9-CM code 45.24; CPT-4 code 45330: endoscopy of the descending colon.

Injection of Other Agent into Spinal Canal - ICD-9-CM code 03.92; CPT-4 codes 62288, 62289, 62298, and 96450: injection of a steroid drug or refrigerated saline into the subarachnoid space.

Injection of Spinal Canal for Analgesia - ICD-9-CM code 03.91; CPT-4 codes 62310, 62311, 62318, and 62319: injection of diagnostic or therapeutic substances including anesthetic, antispasmodic, optoid or steroid.

Laparoscopic Cholecystectomy - ICD-9-CM code 51.23; CPT-4 codes 56340-56342: the removal of the gallbladder performed by a laparoscopic technique.

Left Heart Cardiac Catheterization - ICD-9-CM code 37.22; CPT-4 codes 93510, 93511, and 93514: the insertion of a cardiac catheter into the left heart chambers for the detection or cardiac abnormalities.

Local Excision of Lesion of Breast - ICD-9-CM code 85.21; CPT-4 codes 19112, 19120, 19125, 19126, and 19371: the cutting removal of damaged breast tissue, includes lumpectomy.

Myringotomy with Insertion of Tube - ICD-9-CM code 20.01; CPT-4 codes 69433 and 69436: incision of the eardrum with insertion of a hollow tube for drainage.

Other Cystoscopy - *ICD-9-CM code 57.32; CPT-4 code 52000*: the optical instrumental examination of the bladder, other than through an artificial stoma.

Other Endoscopy of Small Intestine - ICD-9-CM code 45.13; CPT-4 codes 43235 and 43241: the optical instrumental examination of the small intestine, other than inserted through the abdominal wall or an artificial stoma.

Other Extracapsular Extraction of Lens - ICD-9-CM code 13.59; CPT-4 codes 66940 and 66984: removal of the lens of the eye, leaving the posterior capsule intact.

Other Local Excision or Destruction of Lesion of Skin and Subcutaneous Tissue - ICD-9-CM code 86.3; CPT-4 codes 11050-11052, 11200, 11201, 11300-11303, 11450, 11451, 11462,

11463, 11470, 11471, 15000, 17000-17002, 17010, 17100-17102, 17104-17108, 17110, 17200, 17201, 17250, 17260-17264, 17266, 17340, 21555, 23075, 24075, 25075, 26115, 27047, 27327, 27618, and 28043: the cutting removal or forcible death of damaged or other skin and subcutaneous tissue.

Phacoemulsification and Aspiration of Cataract - ICD-9-CM code 13.41; CPT-4 code 66850: removal of the lens of the eye, leaving the posterior capsule intact, using sound waves to liquefy the lens substance before withdrawal by suction.

Tonsillectomy with Adenoidectomy - ICD-9-CM code 28.3; CPT-4 codes 42820 and 43821: surgical removal of the tonsils and adenoids.